**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
**DIVISION OF LONG-TERM CARE**

**REQUEST FOR VOLUNTARY WITHDRAWAL FROM**
**THE MONEY FOLLOWS THE PERSON PROGRAM**

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|---|
| Participant Name: |
| Medicaid ID Number: |
| Transition Coordinator/Case Manager: |
| Provider ID Number: |

❑ I have chosen to withdraw from the participation in the Money Follows the Person (MFP) Project. I am aware that I will no longer be eligible for any services that were directly related to the Money Follows the Person Project. My Transition Coordinator/Case Manager has explained that I will no longer be eligible to receive the following services:

1. Transition Coordination prior to facility discharge, and
2. Transition Services/Funding prior to facility discharge.

☐ My Transition Coordinator/Case Manager has explained that I can still receive my waiver services associated with the waiver in which I am enrolled. The following are examples of those services:

1. Personal Care (either agency or consumer directed); or
2. Respite Care (either agency or consumer directed); or
3. Personal Emergency Response System

☐ Withdrawing from MFP will not effect

1. My Medicaid eligibility; OR
2. My eligibility for the Home and Community Based Care Waiver enrolled in presently.

SIGNATURE – Participant Date Signed

SIGNATURE – Witness (if applicable) Date Signed
A witness may indicate that a participant agreed by making a mark above.

SIGNATURE – Legal Guardian (if applicable) Date Signed

SIGNATURE – Case Manager or Transition Coordinator Date Signed

Agency Name

Telephone Number (including area code)